

1 **BEFORE THE ARIZONA MEDICAL BOARD**

2
3 In the Matter of

4 **SHELDON EPSTEIN, M.D.**

5 Holder of License No. 4811
6 For the Practice of Allopathic Medicine
7 In the State of Arizona.

Board Case No. MD-03-0968A

**FINDINGS OF FACT,
CONCLUSIONS OF LAW
AND ORDER**

(Letter of Reprimand)

8 The Arizona Medical Board ("Board") considered this matter at its public meeting
9 on October 13, 2004. Sheldon Epstein, M.D., ("Respondent") appeared before the
10 Board with legal counsel Judith Berman for a formal interview pursuant to the authority
11 vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue the following
12 findings of fact, conclusions of law and order after due consideration of the facts and
13 law applicable to this matter.

14 **FINDINGS OF FACT**

15 1. The Board is the duly constituted authority for the regulation and control of
16 the practice of allopathic medicine in the State of Arizona.

17 2. Respondent is the holder of License No. 4811 for the practice of allopathic
18 medicine in the State of Arizona.

19 3. The Board initiated case number MD-03-0968A after receiving notification
20 of a medical malpractice settlement regarding Respondent's care and treatment of a 53
21 year-old female patient ("EC").

22 4. EC presented to the Phoenix Baptist Hospital emergency room
23 ("Emergency Room") on October 2, 2000 reporting a three to four day history of mid-
24 abdominal pain with nausea and vomiting. The Emergency Room physician found an
25 umbilical mass that he was unable to reduce. Abdominal x-rays showed dilated loops

1 of small bowel and fluid levels. The Emergency Room physician made a preliminary
2 diagnosis of an incarcerated umbilical hernia. EC was then transferred to the operating
3 room. Respondent was the attending anesthesiologist. During the administration of
4 anesthesia EC regurgitated gastric contents and was suctioned immediately.
5 Respondent subsequently secured EC's airway with a 7.0 endotracheal tube that was
6 left in place.

7 5. At the conclusion of the surgery EC was transferred to the intensive care
8 unit and remained hospitalized for approximately two months. During her
9 hospitalization EC developed aspiration pneumonia and ARDS requiring tracheostomy
10 and long-term ventilatory support. EC also developed neuropathy. EC was later
11 transferred to a rehabilitation hospital, but according to her records, still suffers from
12 problems related to her hospitalization.

13 6. At the beginning of the formal interview Respondent testified that he made
14 an error in judgment and he accepted responsibility for initially using the laryngeal mask
15 airway ("LMA") instead of intubating EC. Respondent noted that when the aspiration
16 occurred he immediately intubated EC. Respondent stated that in the past he has
17 always intubated hernia patients, but he did not intubate EC because preoperatively the
18 surgeon commented that EC had not eaten for three or four days. Respondent also
19 testified that he did not elicit any history of vomiting during his preoperative visit with
20 EC. Respondent testified that he was taken off guard by these statements and he drew
21 the incorrect conclusion that EC had an empty stomach.

22 7. Respondent also testified that he had been told by the surgeon during a
23 previous case that EC's case was a thirty minute adhesiolysis without regurgitation.
24 Based on this information Respondent determined there would be no chance for bowel
25 resection in the abbreviated time frame the surgeon described. Respondent stated that

1 his attention and concentration were diverted from the underlying bowel wall pathology,
2 namely the edema and ischemia. Respondent testified nevertheless, he should have
3 suspected and been prepared for a bowel obstruction and intubated EC at the
4 beginning of the procedure and then passed the nasogastric ("NG") suction tube.
5 Respondent noted that since EC's case he no longer does night cases, emergency
6 cases, and works primarily in an outpatient setting. Respondent stated that this was an
7 unfortunate adverse patient result and is the only such case in his seventeen years of
8 practice prior to October 2000.

9 8. Respondent was asked to explain his normal preoperative patient
10 evaluation. Respondent testified that he asks a series of questions, including when
11 they have eaten last, and then goes over their medical history as to allergies,
12 medications, medical conditions and surgical conditions. Respondent testified that his
13 working diagnosis of EC after evaluating her in the preoperative area was incarcerated
14 umbilical hernia. Respondent was asked in such a case would he typically consider a
15 small bowel issue or a large bowel issue. Respondent stated that since it was umbilical
16 it was probably small bowel. Respondent was commended for his concise workup of
17 EC and his description of the patient and his examination.

18 9. Respondent's notes described the abdomen as distended/tender around
19 the umbilicus. Respondent was asked if in his examination he felt that EC had a bowel
20 obstruction of some sort. Respondent testified that when he sat down in the operating
21 room to complete the anesthesia record after establishing the airway and the vital signs
22 he noticed that there was a small drop-off in the pulse oximetry. Respondent testified
23 that while he was investigating he determined there was regurgitation and acted to
24 intubate her. Respondent stated in quickly filling out the record under "hepatic" he
25 wrote "abdomen distended" and was completing it as quickly as he could and honestly

1 could not think of "scaphoid" as he used in his preoperative examination. Respondent
2 noted that EC had a large abdomen, but kind of scaphoid. And he quickly thought it
3 was distended, but he had not gone on with the note because the record was not his
4 concern. Respondent stated he thought it was scaphoid, upper normal in the pre-
5 operative examination and then when he got involved with the clinical picture he just
6 wrote "distended."

7 10. Respondent's attention was directed to the medical record and it was noted
8 that although he stated he initially put in a LMA, there is no description of a LMA. Also,
9 the record indicated he gave Tracium 30 milligrams and Respondent was asked if
10 Tracium would be given at the beginning of a case with a LMA. Respondent testified
11 that he almost always uses a muscle relaxant, whether Tracium or some other muscle
12 relaxant in a case where he is using a LMA. Respondent noted that it was not totally
13 necessary and some anesthesiologists do not use a muscle relaxant, but he finds it
14 easier to control the airway. Respondent said it also depends on whether the case will
15 be long. If so, he would not use the relaxant. Respondent also noted that, because
16 EC's case was abdominal, the relaxant was required to relax the abdominal
17 musculature.

18 11. Respondent was asked to clarify when the LMA went in and when
19 intubation occurred because the record contains no note of use of the LMA.
20 Respondent testified that the LMA went in immediately after induction. Respondent
21 placed the LMA and then sat down and monitored EC while waiting for the surgeon to
22 begin. Respondent stated he positive pressure ventilated EC by hand. Respondent
23 noted that, with the Tracium, EC was not spontaneously ventilated, she was paralyzed
24 to relax the muscles and to allow better control of the airway. Respondent stated that in
25 his haste he omitted to mention the LMA.

1 12. Respondent was asked the time frame between LMA placement, notice of
2 vomitus and subsequent intubation. Respondent testified that he noticed something
3 was occurring initially when the pulse oximeter on EC's finger, within about five or
4 seven minutes, dropped from 97 to 88 and he was on his feet looking, checking the
5 probe to see whether it moved with the finger, looking at the dials to make sure she was
6 getting adequate oxygen. Respondent stated he was kind of puzzled as to why it was
7 occurring. Respondent testified that he then took his laryngoscope and looked in EC's
8 mouth and could see some bile around the edges of the LMA that sits above the glottis.
9 Respondent testified at that point he quickly took an endotracheal tube and called over
10 the circulator because he knew, as he quickly removed the LMA, there was some bile
11 coming up the airway and he had the circulator standing right beside him to hand him
12 the suction. Respondent stated that each time he tried to place the endotracheal tube
13 there was some bile. Respondent stated that on the third occasion he was able to
14 place the tube and all the attempts took maybe thirty seconds. Respondent noted that
15 all this took place within eight to ten minutes of induction.

16 13. Respondent was asked if, when he found there was a leakage of bile
17 around the LMA tube coming in from the esophagus, he considered maybe trying to
18 take the LMA out and put in a cuffed endotracheal tube, whether to try to pass a
19 laryngeal tube to prevent further aspiration. Respondent testified he just thought he
20 had the situation under control and never thought of or attempted to pass an ("NG")
21 tube through the aperture in the posterior pharynx. Respondent stated he wanted to
22 remove the LMA and intubate EC as quickly as possible to stop the aspiration.

23 14. Respondent was asked why, since he normally places an NG tube in bowel
24 cases, in EC's case he thought it was not necessary. Respondent stated that he was
25 taken off guard by the incorrect conclusion on his part that EC had an empty stomach

1 since she had not eaten in several days and by the surgeon's comments during a
2 previous case that EC's case would be quick, that they were just doing an adhesiolysis.
3 Through these comments he knew there was no time to do a bowel resection.
4 Respondent stated that he did not review the Emergency Room record, but he did
5 interview ED, although she was not the best historian. Respondent did not receive the
6 history of vomiting.

7 13. Respondent was asked what happened from the good pre-operative work-
8 up, the questioning of the patient, to choosing what was clearly not indicated in this
9 case. Respondent stated that all he can say is that he made the wrong conclusion that
10 EC had an empty stomach and from the surgeon's comments he was taken off guard
11 and his attention was diverted from what he normally would consider – the intrinsic
12 pathology of the bowel itself. Respondent stated this gave him a false sense of security
13 that to this day he does not understand.

14 14. The standard of care requires the airway to be secured with a cuffed
15 endotracheal tube.

16 15. Respondent fell below the standard of care because he did not secure the
17 airway with an endotracheal tube.

18 16. EC was harmed by the pulmonary aspiration and prolonged hospitalization
19 and there was potential harm of prolonged and persistent polyneuropathies.

20 **CONCLUSIONS OF LAW**

21 1. The Arizona Medical Board possesses jurisdiction over the subject matter
22 hereof and over Respondent.

23 2. The Board has received substantial evidence supporting the Findings of
24 Fact described above and said findings constitute unprofessional conduct or other
25 grounds for the Board to take disciplinary action.

3. The conduct and circumstances described above constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(26)(q) (“[a]ny conduct or practice that is or might be harmful or dangerous to the patient or the public;”) and 32-1401(26)(ll) (“[c]onduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.”)

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED that:

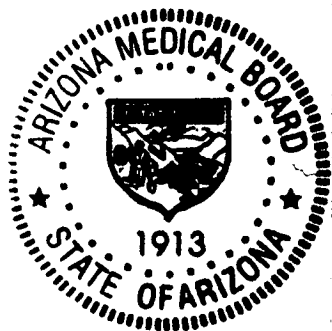
Respondent is issued a Letter of Reprimand for failure to protect the airway of a patient during the administration of an anesthetic.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board within thirty (30) days after service of this Order and must set forth legally sufficient reasons for granting a rehearing or review. A.R.S. § 41-1092.09, A.A.C. R4-16-102, it. Service of this order is effective five (5) days after date of mailing. If a motion for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

1 DATED this 4th day of January, 2005.



THE ARIZONA MEDICAL BOARD

By Timothy C. Miller
TIMOTHY C. MILLER, J.D.
Executive Director

7
8 ORIGINAL of the foregoing filed this
5 day of January, 2005 with:

9 Arizona Medical Board
10 9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

11 Executed copy of the foregoing
12 mailed by U.S. Certified Mail this
13 5 day of January, 2005, to:

14 Judith Berman
15 Doyle Berman Boyack PC
3300 N Central Ave Ste 1600
Phoenix AZ 85012-2524

16 Executed copy of the foregoing
17 mailed by U.S. Mail this
18 5 day of January, 2005, to:

19 Sheldon Epstein, M.D.
Address of Record

20
21 [Signature]
22
23
24
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